

CALIFORNIA CODE OF REGULATIONS

TITLE 22

DIVISION 7

CHAPTER 10  
HEALTH FACILITY DATA

ARTICLE 8  
DISCHARGE DATA REPORTING REQUIREMENTS

**97210. Contact Person, User Account Administrator, Designated Agent, and Facility Identification Number.**

(a) Each hospital shall designate a Discharge Data primary contact person and shall notify the Office's Discharge Data Program in writing, by electronic mail or through the Medical Information Reporting for California (MIRCal) system of the designated person's name, title, telephone number(s), mailing address, and electronic mail address.

(b) Each hospital shall notify the Office's Discharge Data Program in writing, by electronic mail, or through the MIRCal system within 15 days after any change in the person designated as the patient discharge data primary contact person, or in the designated primary person's name, title, telephone number(s), mailing address or electronic mail address.

(c) Each hospital beginning or resuming operations, whether in a newly constructed facility or in an existing facility, shall notify the Office's Discharge Data Program in writing, by electronic mail or through the MIRCal system within 30 days after its first day of operation of the designated primary contact person and the facility administrator

(d) Each hospital shall designate up to three User Account Administrators pursuant to Subsection (f) of Section 97246. Each hospital shall notify the Office's Discharge Data Program in writing, by electronic mail or through the MIRCal system within 15 days after any change in a designated user account administrator's name, title, telephone number(s), mailing address, or electronic mail address.

(e) Each hospital may submit its own discharge data report to the Office's Discharge Data Program, or it may designate an agent for this purpose. The hospital shall be responsible for ensuring compliance with regulations and reporting requirements when an agent is designated pursuant to Subsection (b) of Section 97246.

(f) Each hospital shall be provided a facility identification number that shall be used to submit data to the Office.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

**97211. Reporting Periods and Due Dates.**

(a) The prescribed reporting period is calendar semiannual, which means that there are two reporting periods each year, consisting of discharges occurring January 1 through June 30 and discharges occurring July 1 through December 31.

(b) Where there has been a change in the licensee of a hospital, the effective date of the change in licensee shall constitute the start of the reporting period for the new licensee, and this first reporting period shall end on June 30 or December 31, whichever occurs first. The final day of the reporting period for the previous licensee shall be the last day their licensure was effective.

(c) For discharges occurring on or after January 1, 2003, and all subsequent report periods, the report due date shall be three months after the end of each reporting period; thus the due date for the January 1 through June 30 reports is September 30 of the same year and the due date for the July 1 through December 31 reports is March 31 of the following year.

(d) Discharge data reports shall be filed, as defined by Subsection (f) of Section 97005, by the date the discharge data report is due. Where a hospital has been granted an extension, pursuant to Section 97241, the ending date of the extension shall constitute the new due date for that discharge data report.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

## **97212. Definitions, as used in this Article.**

(a) California Hospital Discharge Data Set. The California Hospital Discharge Data Set consists of the data elements of the hospital discharge abstract data record, as specified in Subsection (g) of Section 128735 of the Health and Safety Code.

(b) Days. Days, as used in this article, are defined as calendar days unless otherwise specified.

(c) Designated Agent. An entity designated by a hospital to submit that hospital's discharge data records to the Office's Discharge Data Program; may include the hospital's abstractor, a data processing firm, or the data processing unit in the hospital's corporate office.

(d) Discharge. A discharge is defined as a newborn or a person who was formally admitted to a hospital as an inpatient for observation, diagnosis, or treatment, with the expectation of remaining overnight or longer, and who is discharged under one of the following circumstances:

(1) is formally discharged from the care of the hospital and leaves the hospital,

(2) transfers within the hospital from one type of care to another type of care, as defined by Subsection (o) of Section 97212, or

(3) has died.

(e) DRG. Diagnosis Related Groups is a classification scheme with which to categorize patients according to clinical coherence and expected resource intensity, as indicated by their diagnoses, procedures, age, sex, and disposition, and was established and is revised annually by the U.S. Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services (CMS), formerly known as the U.S. Health Care Financing Administration.

(f) Do Not Resuscitate (DNR) Order. A DNR order is a directive from a physician in a patient's current inpatient medical record instructing that the patient is not to be resuscitated in the event of a cardiac or pulmonary arrest. In the event of a cardiac or pulmonary arrest, resuscitative measures include, but are not limited to, the following: cardiopulmonary resuscitation (CPR), intubation, defibrillation, cardioactive drugs, or assisted ventilation.

(g) Error. Error means any record found to have an invalid entry or to contain incomplete data or to contain illogical data.

(h) Facility Identification Number. A unique six-digit number that shall be assigned to each facility and shall be used to identify the facility.

(i) ICD-9-CM. The International Classification of Diseases, 9th Revision, Clinical Modification, published by the U.S. Department of Health and Human Services. Coding guidelines and annual revisions to ICD-9-CM are made nationally by the "cooperating parties" (the American Hospital Association, the Centers for Medicare and Medicaid Services, the National Center for Health Statistics, and the American Health Information Management Association).

(j) Licensee. Licensee means an entity that has been issued a license to operate a hospital, as defined by Subdivision (c) of Section 128700 of the Health and Safety Code.

(k) MIRCal. MIRCal means the OSHPD Medical Information Reporting for California system that is the online transmission system through which data are submitted using an Internet web browser either by file transfer or data entry. It is a secure means of electronic transmission of data in an automated environment and allows facilities to edit and correct data held in a storage database until reports meet or exceed the Approval Criteria specified in Section 97247.

(l) Record. A record is defined as the set of data elements of the "hospital discharge abstract data record," as specified in Subdivision (g) of Section 128735 of the Health and Safety Code, for one patient.

(m) Report. A report is defined as the collection of all records submitted by a hospital for a semiannual reporting period or for a shorter period, pursuant to Subsection (b) of Section 97211.

(n) Reporting Facility. Reporting facility means a hospital required to submit the data elements of the hospital discharge abstract data record, as specified in Subdivision (g) of Section 128735 of the Health and Safety Code.

(o) Type of Care. Type of care is defined as one of the following:

(1) Skilled nursing/intermediate care. Skilled nursing/intermediate care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license in the classifications of skilled nursing or intermediate care, as defined by paragraphs (2), (3), or (4) of Subdivision (a) of Section 1250.1 of the Health and Safety Code. Skilled nursing/intermediate care also means inpatient care that is provided to inpatients occupying general acute care beds that are being used to provide skilled nursing/intermediate care to those inpatients in an approved swing bed program.

(2) Physical rehabilitation care. Physical rehabilitation care means inpatient care that is provided to inpatients occupying beds included on a hospital's license within the general acute care classification, as defined by paragraph (1) of Subdivision (a) of Section 1250.1 of the Health and Safety Code, and designated as rehabilitation center beds, as defined by Subsection (a) of Section 70034 and by Section 70595 of Title 22 of the California Code of Regulations.

(3) Psychiatric care. Psychiatric care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license in the classification of acute psychiatric beds, as defined by paragraph (5) of Subdivision (a) Section 1250.1 of the Health and Safety Code, and psychiatric health facility, as defined by Subdivision (a) of Section 1250.2 of the Health and Safety Code.

(4) Chemical dependency recovery care. Chemical dependency recovery care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license as chemical dependency recovery beds, as defined by paragraph (7) of Subdivision (a) of Section 1250.1 of the Health and Safety Code and Subdivisions (a), (c), or (d) of Section 1250.3 of the Health and Safety Code.

(5) Acute care. Acute care, as defined by paragraph (1) of Subdivision (a) of Section 1250.1 of the Health and Safety Code, means all other types of inpatient care provided to inpatients occupying all other types of licensed beds in a hospital, other than those defined by paragraphs (1), (2), (3) and (4) of Subsection (o) of this section.

(p) User Account Administrator. A healthcare facility representative responsible for maintaining the facility's MIRCAl user accounts and user account contact information.

Authority: Section 128810, Health and Safety Code.

Reference: Sections 128735, 1250, and 1250.1, Health and Safety Code.

### **97213. Required Reporting.**

(a) Each hospital shall submit the data elements of the hospital discharge abstract data record, as specified in Subdivision (g) of Section 128735 of the Health and Safety Code, for each inpatient discharged during the semiannual reporting period, according to the format specified in Section 97215 and by the dates specified in Section 97211.

(b) A hospital shall separately identify records of patients being discharged from the acute care type of care, as defined by paragraph (5) of Subsection (o) of Section 97212. The hospital shall identify these records by recording a "1" on each of these records as specified in the Format and Specifications for Online Transmission in Section 97215.

(c) A hospital shall separately identify records of patients being discharged from the skilled nursing/intermediate care type of care, as defined by paragraph (1) of Subsection (o) of Section 97212. The hospital shall identify these records by recording a "3" on each of these records as specified in the Format and Specifications for Online Transmission in Section 97215.

(d) A hospital shall separately identify records of patients being discharged from the psychiatric care type of care, as defined by paragraph (3) of Subsection (o) of Section 97212. The hospital shall identify these records by recording a "4" on each of these records as specified in the Format and Specifications for Online Transmission in Section 97215.

(e) A hospital shall separately identify records of patients being discharged from the chemical dependency recovery care type of care, as defined by paragraph (4) of Subsection (o) of Section 97212. The hospital shall identify these records by recording a "5" on each of these records as specified in the Format and Specifications for Online Transmission in Section 97215.

(f) A hospital shall separately identify records of patients being discharged from the physical rehabilitation care type of care, as defined by paragraph (2) of Subsection (o) of Section 97212. The hospital shall identify these records by recording a "6" on each of these records as specified in the Format and Specifications for Online Transmission in Section 97215.

(g) Each discharge data report shall be submitted at one time and shall include all types of care.

(h) Licensees operating and maintaining more than one physical plant on separate premises under a single consolidated hospital license who choose to file separate discharge data reports for each location must request, in writing, a modification to file separate discharge data reports for each location. A licensee granted a modification under this paragraph shall be responsible for all regulatory requirements for each separate report. Separate extension requests, filed under the provisions of Section 97241, shall be required for each report, and penalties, assessed pursuant to Section 97250, shall be assessed on each delinquent report.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

**97215. Format.**

Discharge Data reports for discharges occurring on or after January 1, 2003, shall comply with the Office's Format and Specifications for Online Transmission, dated May 2003, and hereby incorporated by reference. The Office's Format and Specifications for Online Transmission are available for download from the MIRCAl website. The Office will make a hardcopy of the Office's Format and Specifications for Online Transmission available to a hospital or designated agent upon request.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

**97216. Definition of Data Element—Date of Birth.**

The patient's birth date shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year of birth. The numeric form for days and months from 1 to 9 must have a zero as the first digit. When the complete date of birth is unknown, as much of the date as is known shall be reported. At a minimum, an approximate year of birth shall be reported. If only the age is known, the estimated year of birth shall be reported. If the month and year of birth are known, and the exact day is not, the year, the month, and zeros for the day shall be reported.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

**97217. Definition of Data Element—Sex.**

The patient's gender shall be reported as male, female, other, or unknown. "Other" includes sex changes, undetermined sex, and live births with congenital abnormalities that obscure sex identification. "Unknown" indicates that the patient's sex was not available from the medical record.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

**97218. Definition of Data Element—Race.**

Effective with discharges on January 1, 1995, the patient's ethnic and racial background shall be reported as one choice from the following list of alternatives under ethnicity and one choice from the following list of alternatives under race:

(a) Ethnicity:

(1) Hispanic. A person who identifies with or is of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin.

(2) Non-Hispanic.

(3) Unknown.

(b) Race:

(1) White. A person having origins in or who identifies with any of the original caucasian peoples of Europe, North Africa, or the Middle East.

(2) Black. A person having origins in or who identifies with any of the black racial groups of Africa.

(3) Native American/Eskimo/Aleut. A person having origins in or who identifies with any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

(4) Asian/Pacific Islander. A person having origins in or who identifies with any of the original oriental peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. Includes Hawaii, Laos, Vietnam, Cambodia, Hong Kong, Taiwan, China, India, Japan, Korea, the Philippine Islands, and Samoa.

(5) Other. Any possible options not covered in the above categories.

(6) Unknown.

Authority: Section 128810, Health and Safety Code.  
Reference: Section 128735, Health and Safety Code.

**97219. Definition of Data Element—ZIP Code.**

The "ZIP Code," a unique code assigned to a specific geographic area by the U.S. Postal Service, for the patient's usual residence shall be reported for each patient discharge. Foreign residents shall be reported as "YYYYY" and unknown ZIP Codes shall be reported as "XXXXX." If the city of residence is known, but not the street address, report the first three digits of the ZIP Code, and the last two digits as zeros. Hospitals shall distinguish the "homeless" (patients who lack a residence) from other patients lacking a numeric ZIP Code of residence by reporting the ZIP Code of homeless patients as "ZZZZZ." If the patient has a 9-digit ZIP Code, only the first five digits shall be reported.

Authority: Section 128810, Health and Safety Code.  
Reference: Section 128735, Health and Safety Code.

**97220. Definition of Data Element—Patient Social Security Number.**

The patient's social security number is to be reported as a 9-digit number. If the patient's social security number is not recorded in the patient's medical record, the social security number shall be reported as "not in medical record," by reporting the social security number as "000000001." The number to be reported is to be the patient's social security number, not the social security number of some other person, such as the mother of a newborn or the insurance beneficiary under whose account the hospital's bill is to be submitted.

Authority: Section 128810, Health and Safety Code.  
Reference: Section 128735, Health and Safety Code.

**97221. Definition of Data Element—Admission Date.**

The patient's date of admission shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit. For discharges representing a transfer of a patient from one type of care within the hospital to another type of care within the hospital, as defined by Subsection (i) of Section 97212 and reported pursuant to Section 97212, the admission date reported shall be the date the patient was transferred to the type of care being reported on this record.

Authority: Section 128810, Health and Safety Code.  
Reference: Section 128735, Health and Safety Code.

**97222. Definition of Data Element—Source of Admission.**

Effective with discharges on or after January 1, 1997, in order to describe the patient's source of admission, it is necessary to address three aspects of the source: first, the site from which the patient originated; second, the licensure of the site from which the patient originated; and, third, the route by which the patient was admitted. One alternative shall be selected from the list following each of three aspects:

(a) The site from which the patient was admitted.

(1) Home. A patient admitted from the patient's home, the home of a relative or friend, or a vacation site, whether or not the patient was seen at an outpatient clinic or physician's office, or had been receiving home health services or hospice care at home.

(2) Residential Care Facility. A patient admitted from a facility in which the patient resides and that provides special assistance to its residents in activities of daily living, but that provides no organized healthcare.

(3) Ambulatory Surgery. A patient admitted after treatment or examination in an ambulatory surgery facility, whether hospital-based or a freestanding licensed ambulatory surgery clinic or certified ambulatory surgery center. Excludes outpatient clinics and physicians' offices not licensed and/or certified as an ambulatory surgery facility.

(4) Skilled Nursing/Intermediate Care. A patient admitted from skilled nursing care or intermediate care, whether freestanding or hospital-based, or from a Congregate Living Health Facility, as defined by Subdivision (i) of Section 1250 of the Health and Safety Code.

(5) Acute Hospital Care. A patient who was an inpatient at a hospital, and who was receiving inpatient hospital care of a medical/surgical nature, such as in a perinatal, pediatric, intensive care, coronary care, respiratory care, newborn intensive care, or burn unit of a hospital.

(6) Other Hospital Care. A patient who was an inpatient at a hospital, and who was receiving inpatient hospital care not of a medical/surgical nature, such as in a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit.

(7) Newborn. A baby born alive in this hospital.

(8) Prison/Jail. A patient admitted from a correctional institution.

(9) Other. A patient admitted from a source other than mentioned above. Includes patients admitted from a freestanding, not hospital-based, inpatient hospice facility.

(b) Licensure of the site.

(1) This Hospital. The Ambulatory Surgery, Skilled Nursing/Intermediate Care, Acute Hospital Care, or Other Hospital Care from which the patient was admitted was operated as part of the license of this hospital. Includes all newborns.

(2) Another Hospital. The Ambulatory Surgery, Skilled Nursing/Intermediate Care, Acute Hospital Care, or Other Hospital Care from which the patient was admitted was operated as part of the license of some other hospital.

(3) Not a Hospital. The site from which the patient was admitted was not operated under the license of a hospital. Includes all patients admitted from Home, Residential Care, Prison/Jail, and Other sites. Includes patients admitted from Ambulatory Surgery or Skilled Nursing/Intermediate Care sites that were not operated under the authority of the license of any hospital. Excludes all patients admitted from Acute Hospital Care or Other Hospital Care.

(c) Route of admission.

(1) Your Emergency Room. Any patient admitted as an inpatient after being treated or examined in this hospital's emergency room. Excludes patients seen in the emergency room of another hospital.

(2) Not Your Emergency Room. Any patient admitted as an inpatient without being treated or examined in this hospital's emergency room. Includes patients seen in the emergency room of some other hospital and patients not seen in any emergency room.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

**97223. Definition of Data Element—Type of Admission.**

Effective with discharges on January 1, 1995, the patient's type of admission shall be reported using one of the following categories:

(a) Scheduled. Admission was arranged with the hospital at least 24 hours prior to the admission.

(b) **Unscheduled.** Admission was not arranged with the hospital at least 24 hours prior to the admission.

(c) **Infant.** An infant less than 24 hours old.

(d) **Unknown.** Nature of admission not known. Does not include stillbirths.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

**97224. Definition of Data Element—Discharge Date.**

The patient's date of discharge shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

**97225. Definition of Data Element—Principal Diagnosis and Whether the Condition was Present at Admission.**

(a) The patient's principal diagnosis, defined as the condition established, after study, to be the chief cause of the admission of the patient to the facility for care, shall be coded according to the ICD-9-CM.

(b) Effective with discharges on or after January 1, 1996, whether the patient's principal diagnosis was present at admission shall be reported as one of the following:

(1) Yes.

(2) No.

(3) Uncertain.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

**97226. Definition of Data Element—Other Diagnoses and Whether the Conditions were Present at Admission.**

(a) The patient's other diagnoses are defined as all conditions that coexist at the time of admission, that develop subsequently during the hospital stay, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode

that have no bearing on the current hospital stay are to be excluded. Diagnoses shall be coded according to the ICD-9-CM. ICD-9-CM codes from the supplementary classification of external causes of injury and poisoning (E800-E999) shall not be reported as other diagnoses.

(b) Effective with discharges on or after January 1, 1996, whether the patient's other diagnoses were present at admission shall be reported as one of the following:

(1) Yes.

(2) No.

(3) Uncertain.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

**97227. Definition of Data Element—External Cause of Injury.**

The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), that are codes used to describe the external causes of injuries, poisonings, and adverse effects. If the information is available in the medical record, E-codes sufficient to describe the external causes shall be reported for discharges with a principal and/or other diagnoses classified as injuries or poisonings in Chapter 17 of the ICD-9-CM (800-999), or where a code from Chapters 1-16 of the ICD-9-CM (001-799) indicates that an additional E-code is applicable, except that the reporting of E-codes in the range E870-E879 (misadventures and abnormal reactions) are not required to be reported. An E-code is to be reported only for the first inpatient hospitalization during which the injury, poisoning, and/or adverse effect was diagnosed and/or treated. To assure uniform reporting of E-codes, when multiple codes are required to completely classify the cause, the first (principal) E-code shall describe the mechanism that resulted in the most severe injury, poisoning, or adverse effect. If the principal E-code does not include a description of the place of occurrence of the most severe injury or poisoning, an E-code shall be reported to designate the place of occurrence, if available in the medical record. Additional E-codes shall be reported, if necessary to completely describe the mechanisms that contributed to, or the causal events surrounding, any injury, poisoning, or adverse effect first diagnosed and/or treated during the current inpatient hospitalization.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

**97228. Definition of Data Element—Principal Procedure and Date.**

The patient's principal procedure is defined as one that was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. If there appear to be two procedures that are principal, then the one most related to the principal diagnosis should be selected as the principal procedure. Procedures shall be coded according to the ICD-9-CM. If only non-therapeutic procedures were performed, then a non-therapeutic procedure should be reported as the principal procedure, if it was a significant procedure. A significant procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk, or is needed for DRG assignment. The date the principal procedure was performed shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

**97229. Definition of Data Element—Other Procedures and Dates.**

All significant procedures are to be reported. A significant procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk, or is needed for DRG assignment. Procedures shall be coded according to the ICD-9-CM. The dates shall be recorded with the corresponding other procedures and be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

**97230. Definition of Data Element—Total Charges.**

The total charges are defined as all charges for services rendered during the length of stay for patient care at the facility, based on the hospital's full established rates. Charges shall include, but not be limited to, daily hospital services, ancillary services, and any patient care services. Hospital-based physician fees shall be excluded. Prepayment (e.g., deposits and prepaid admissions) shall not be deducted from Total Charges. If a patient's length of stay is more than 1 year (365 days), report Total Charges for the last year (365 days) of stay only.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

**97231. Definition of Data Element—Disposition of Patient.**

Effective with discharges on or after January 1, 1997, the patient's disposition, defined as the consequent arrangement or event ending a patient's stay in the reporting facility, shall be reported as one of the following:

(a) Routine Discharge. A patient discharged from this hospital to return home or to another private residence. Patients scheduled for follow-up care at a physician's office or a clinic shall be included. Excludes patients referred to a home health service.

(b) Acute Care Within This Hospital. A patient discharged to inpatient hospital care that is of a medical/surgical nature, such as to a perinatal, pediatric, intensive care, coronary care, respiratory care, newborn intensive care, or burn unit within this reporting hospital.

(c) Other Type of Hospital Care Within This Hospital. A patient discharged to inpatient hospital care not of a medical/surgical nature and not skilled nursing/intermediate care, such as to a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit within this reporting hospital.

(d) Skilled Nursing/Intermediate Care Within This Hospital. A patient discharged to a Skilled Nursing/Intermediate Care Distinct Part within this reporting hospital.

(e) Acute Care at Another Hospital. A patient discharged to another hospital to receive inpatient care that is of a medical/surgical nature, such as to a perinatal, pediatric, intensive care, coronary care, respiratory care, newborn intensive care, or burn unit of another hospital.

(f) Other Type of Hospital Care at Another Hospital. A patient discharged to another hospital to receive inpatient hospital care not of a medical/surgical nature and not skilled nursing/intermediate care, such as to a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit of another hospital.

(g) Skilled Nursing/Intermediate Care Elsewhere. A patient discharged from this hospital to a Skilled Nursing/Intermediate Care type of care, either freestanding or a distinct part within another hospital, or to a Congregate Living Health Facility, as defined by Subsection (i) of Section 1250 of the Health and Safety Code.

(h) Residential Care Facility. A patient discharged to a facility that provides special assistance to its residents in activities of daily living, but that provides no organized healthcare.

(i) Prison/Jail. A patient discharged to a correctional institution.

(j) Against Medical Advice. Patient left the hospital against medical advice, without a physician's discharge order. Psychiatric patients discharged from away without leave (AWOL) status are included in this category.

(k) Died. All episodes of inpatient care that terminated in death. Patient expired after admission and before leaving the hospital.

(l) Home Health Service. A patient referred to a licensed home health service program.

(m) Other. A patient discharged to some place other than mentioned above. Includes patients discharged to a freestanding, not hospital-based, inpatient hospice facility.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

**97232. Definition of Data Element—Expected Source of Payment.**

(a) Effective with discharges on or after January 1, 1999, the patient's expected source of payment shall be reported using the following:

(1) Payer Category: The type of entity or organization which is expected to pay or did pay the greatest share of the patient's bill.

(A) Medicare. A federally administered third party reimbursement program authorized by Title XVIII of the Social Security Act. Includes crossovers to secondary payers.

(B) Medi-Cal. A state administered third party reimbursement program authorized by Title XIX of the Social Security Act.

(C) Private Coverage. Payment covered by private, non-profit, or commercial health plans, whether insurance or other coverage, or organizations. Included are payments by local or organized charities, such as the Cerebral Palsy Foundation, Easter Seals, March of Dimes, Shriners.

(D) Workers' Compensation. Payment from workers' compensation insurance, government or privately sponsored.

(E) County Indigent Programs. Patients covered under Welfare and Institutions Code Section 17000. Includes programs funded in whole or in part by County Medical Services Program (CMSP), California Healthcare for Indigents Program (CHIP), and/or Realignment Funds whether or not a bill is rendered.

(F) Other Government. Any form of payment from government agencies, whether local, state, federal, or foreign, except those in Subsections (a)(1)(A), (a)(1)(B), (a)(1)(D), or (a)(1)(E) of this section. Includes funds received through the California Children Services (CCS), the Civilian Health and Medical Program of the Uniformed Services (TRICARE), and the Veterans Administration.

(G) Other Indigent. Patients receiving care pursuant to Hill-Burton obligations or who meet the standards for charity care pursuant to the hospital's established charity care policy. Includes indigent patients, except those described in Subsection (a)(1)(E) of this section.

(H) Self Pay. Payment directly by the patient, personal guarantor, relatives, or friends. The greatest share of the patient's bill is not expected to be paid by any form of insurance or other health plan.

(I) Other Payer. Any third party payment not included in Subsections (a)(1)(A) through (a)(1)(H) of this section. Included are cases where no payment will be required by the facility, such as special research or courtesy patients.

(2) Type of Coverage. For each Payer Category, Subsections (a)(1)(A) through (a)(1)(F) of this section, select one of the following Types of Coverage:

(A) Managed Care - Knox-Keene/Medi-Cal County Organized Health System. Health care service plans, including Health Maintenance Organizations (HMO), licensed by the Department of Corporations under the Knox-Keene Health Care Service Plan Act of 1975. Includes Medi-Cal County Organized Health Systems.

(B) Managed Care - Other. Health care plans, except those in Subsection (a)(2)(A) of this section, which provide managed care to enrollees through a panel of providers on a pre-negotiated or per diem basis, usually involving utilization review. Includes Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), Exclusive Provider Organization with Point-of-Service option (POS).

(C) Traditional Coverage. All other forms of health care coverage, including the Medicare prospective payment system, indemnity or fee-for-service plans, or other fee-for-service payers.

(3) Name of Plan.

(A) For discharges occurring on or after January 1, 2000, report the names of those plans which are licensed under the Knox-Keene Health Care Service Plan Act of 1975 or designated as a Medi-Cal County Organized Health System. For Type of Coverage, Subsection (a)(2)(A) of this section, report the plan code number representing the name of the Knox-Keene licensed plan as shown in Table 1. or the

Medi-Cal County Organized Health System as shown in Table 2.

Table 1. Knox-Keene Licensed Plans and Plan Code Numbers: For use with discharges occurring in 2000, 2001, 2002, and 2003	
Plan Code Names	Plan Code Numbers
Aetna Health Plans of California, Inc.	0176
Alameda Alliance for Health	0328
Blue Cross of California	0303
Blue Shield of California	0043
BPS HMO	0314
Calaveras Provider Network	0365
Care 1st Health Plan	0326
Cedars-Sinai Provider Plan, LLC	0366
Chinese Community Health Plan	0278
Cigna Healthcare of California, Inc.	0152
Community Health Group	0200
Community Health Plan (County of Los Angeles)	0248
Concentrated Care, Inc.	0360
Contra Costa Health Plan	0054
FPA Medical Management of California, Inc	0350
Great American Health Plan	0327
Greater Pacific HMO Inc	0317
HAI, Hai-Ca	0292
Healthmax America	0277
Health Net	0300
Health Plan of America (HPA)	0126
Health Plan of the Redwoods	0159
Health Plan of San Mateo	0358
Heritage Provider Network, Inc.	0357
Holman Professional Counseling Centers	0231
Inland Empire Health Plan	0346
Inter Valley Health Plan	0151
Kaiser Foundation Added Choice Health Plan	0289
Kaiser Foundation Health Plan, Inc.	0055
Kern Health Systems Inc	0335
Key Health Plan of California	0343
Key HMO Key Choice	0343
Lifeguard, Inc.	0142
LA Care Health Plan	0355
Managed Health Network	0196
Maxicare	0002

MCC Behavioral Care of California, Inc.	0298
MedPartners Provider Network, Inc.	0345
Metrahealth Care Plan	0266
Merit Behavioral Care of California, Inc.	0288
Molina	0322
National Health Plans	0222
National HMO	0222
Omni Healthcare, Inc.	0238
One Health Plan of California Inc.	0325
On Lok Senior Health Services	0385
Pacificare Behavioral Health of California Inc.	0301
Pacificare of California	0126
Primecare Medical Network, Inc. A CA. Corp.	0367
Priorityplus of California	0237
Prucare Plus	0296
Qualmed Plans for Health/Bridgeway	0300
Regents of the University of California	0354
San Francisco Health Plan	0349
Santa Clara Family Health Plan	0351
Scripps Clinic Health Plan Services, Inc.	0377
Secure Horizons	0126
Sharp Health Plan	0310
Simnsa Health Care	0393
Sistemas Medicos Nacionales, S.A. De C.V.	0393
Smartcare Health Plan	0212
The Health Plan of San Joaquin	0338
Thipa Management Consultants, Incorporated	0363
Tower Health Service	0324
UHC Healthcare	0266
UHP Healthcare	0008
Universal Care	0209
Valley Health Plan	0236
Value Behavioral Health & American Psychol.	0293
Ventura County Health Care Plan	0344
Vista Behavioral Health Plan	0102
Western Health Advantage	0348
Other	8000

Table 2. Medi-Cal County Organized Health Systems and Plan Code Numbers For use with discharges occurring in 2000, 2001, 2002 and 2003	
Name of Medi-Cal County Organized Health System	Plan Code Numbers
Cal Optima (Orange County)	9030
Health Plan of San Mateo (San Mateo County)	9041
Santa Barbara Health Authority (Santa Barbara County)	9042
Central Coast Alliance For Health (Santa Cruz County)	9044
Solano Partnership Health Plan (Solano County)	9048

(B) For discharges occurring on or after January 1, 2004, report the names of those plans which are licensed under the Knox-Keene Health Care Service Plan Act of 1975 or designated as a Medi-Cal County Organized Health System. For Type of Coverage, Subsection (a)(2)(A) of this section, report the plan code number representing the name of the Knox-Keene licensed plan or the Medi-Cal County Organized Health System as shown in Table 1.

Table 1. Knox-Keene Licensed Plans, Medi-Cal County Organized Health Systems and Plan Code Numbers: For use with discharges occurring on or after January 1, 2004	
Plan Code and Medi-Cal County Organized Health System Names	Plan Code Numbers
AET Health Care Plan Of California	0296
Aetna Health Plans of California, Inc.	0176
Alameda Alliance for Health	0328
American Family Care	0322
Avante Behavioral Health Plan	0397
Blue Cross of California	0303
Blue Shield of California	0043
Caloptima (Orange County)	0394
Care 1st Health Plan	0326
CareMore Insurance Services, Inc	0408
Cedars-Sinai Provider Plan, LLC	0366
Central Coast Alliance For Health (Santa Cruz County / Monterey County)	0401
Central Health Plan	0404

Chinese Community Health Plan	0278
Cigna Behavioral Health of California	0298
Cigna HealthCare of California, Inc.	0152
Community Health Group	0200
Community Health Plan (County of Los Angeles)	0248
Contra Costa Health Plan	0054
HAI, Hai-Ca	0292
Health Net of California, Inc.	0300
Health Plan of America (HPA)	0126
Health Plan of the Redwoods	0159
(The) Health Plan of San Joaquin	0338
Health Plan of San Mateo	0358
Heritage Provider Network, Inc.	0357
HHRC, Integrated Insights	0319
Holman Professional Counseling Centers	0231
Inland Empire Health Plan (IEHP)	0346
Inter Valley Health Plan	0151
Kaiser Foundation Health Plan, Inc.	0055
Kern Health Systems Inc	0335
Lifeguard, Inc.	0142
LA Care Health Plan	0355
Managed Health Network	0196
Medcore HP	0390
Merit Behavioral Care of California, Inc. (MBC)	0288
Molina Healthcare of California	0322
One Health Plan of California Inc.	0325
On Lok Senior Health Services	0385
PacifiCare Behavioral Health of California	0301
PacifiCare of California	0126
Primecare Medical Network, Inc.	0367
ProMed Health Care Administrators	0380
Regents of the University of California	0354
San Francisco Health Plan	0349
Santa Barbara Regional Health Authority	0400
Santa Clara Family Health Plan	0351
Santa Clara Valley Med. Ctr.	0236
SCAN Health Plan	0212
Scripps Clinic Health Plan Services, Inc.	0377
Secure Horizons	0126
Sharp Health Plan	0310
Simnsa Health Care	0393
Sistemas Medicos Nacionales, S.A. De C.V.	0393

Smartcare Health Plan	0212
Solano Partnership Health Plan (Solano County)	9048
The Health Plan of San Joaquin	0338
UHP Healthcare	0008
Universal Care	0209
U.S. Behavioral Health Plan, California	0259
Valley Health Plan	0236
ValueOptions of California, Inc.	0293
Ventura County Health Care Plan	0344
Vista Behavioral Health Plan	0102
Western Health Advantage	0348
Other	8000

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

**97233. Definition of Data Element—Prehospital Care and Resuscitation.**

Effective with discharges on or after January 1, 1999, information about resuscitation orders in a patient's current medical record shall be reported as follows:

(a) Yes, a DNR order was written at the time of or within the first 24 hours of the patient's admission to the hospital.

(b) No, a DNR order was not written at the time of or within the first 24 hours of the patient's admission to the hospital.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

**97240. Request for Modifications to the California Hospital Discharge Data Set.**

(a) Hospitals may file a request with the Office for modifications to the California Hospital Discharge Data Set. The modification request must be supported by a detailed justification of the hardship that full reporting of discharge data would have on the hospital; an explanation of attempts to meet discharge data reporting requirements; and a description of any other factors that might justify a modification. Modifications may be approved for only one year. Each hospital with an approved modification must request a renewal of that approval 60 days prior to termination of the approval period in order to have the modification continue in force.

(b) The criteria to be considered and weighed by the Office in determining whether a modification to discharge data reporting requirements may be granted are as follows:

(1) The modification would not impair the ability of either providers or consumers to make informed healthcare decisions.

(2) The modification would not deprive the public of discharge data needed to make comparative choices with respect to scope or type of services or to how services are provided, and with respect to the manner of payment.

(3) The modification would not impair any of the goals of the Act.

Authority: Section 128810, Health and Safety Code.

Reference: Sections 128735 and 128760, Health and Safety Code.

#### **97241. Extensions of Time to File Discharge Data Reports.**

(a) Extensions are available to hospitals that are unable to complete their submission of discharge data reports by the due date prescribed in Section 97211.

(1) Requests for extension shall be postmarked or filed on or before the required due date of the discharge data report and supported by a written justification that must provide sufficient cause for the approval of the extension request. To provide the Office a basis to determine sufficient cause, the written justification shall include a factual statement indicating:

(A) the actions taken by the hospital to produce the discharge data report by the required deadline;

(B) those factors that prevent completion of the discharge data report by the deadline; and

(C) those actions and the time (days) needed to accommodate those factors.

(2) The Office shall respond within 5 days of receipt of the request by either granting what is determined to be a reasonable extension or disapproving the request. If disapproved, the Office shall set forth the basis for a denial in a notice to the hospital sent by certified mail. The Office may seek additional information from the requesting hospital. The Office shall not grant extensions that exceed the maximum number of days available for the report period for all extensions. If a hospital submits the discharge data report prior to the due date of an extension, those days not used will be applied to the number of remaining extension days. A hospital that wishes to contest any decision of the Office shall have the right to appeal, pursuant to Section 97052.

(b) A maximum of 45 extension days will be allowed for all extensions and resubmittals of reports with discharges occurring in the January 1, through June 30, 2003, and the July 1, through December 31, 2003 report periods.

(c) A maximum of 28 extension days will be allowed for all extensions and resubmittals of reports with discharges occurring in the January 1, through June 30, 2004, and the July 1, through December 31, 2004 report periods.

(d) A maximum of 14 extension days will be allowed for all extensions and resubmittals of reports with discharges occurring on or after January 1, 2005.

(e) If a report is rejected on, or within 7 days before, or at any time after, any due date established by Subsections (c), (d), or (e), of Section 97211, the Office shall grant, if available, an extension of 7 days. If less than 7 days are available all available extension days will be granted.

(f) If the Office determines that the MIRCal system was unavailable for data submission for one or more periods of 4 or more continuous supported hours during the 4 State working days before a due date established pursuant to Section 97211, the Office shall extend the due date by 7 days.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

#### **97244. Method of Submission.**

(a) Hospitals shall use the MIRCal system for report periods beginning on or after January 1, 2003. Data shall be reported utilizing a Microsoft Internet Explorer web browser that supports a secure Internet connection utilizing the Secure Hypertext Transfer Protocol (HTTPS or https) and 128-bit cypher strength Secure Socket Layer (SSL) through either:

(1) Online transmission of data reports as electronic data files, or

(2) Online entry of individual records.

(b) If an approved exemption is on file with the Office, pursuant to Health and Safety Code Section 128755, a hospital may report discharges on or after January 1, 2003 by computer tape (reel or cartridge), diskette, compact disk or Manual Abstract Reporting Form, provided the hospital complies with the Office's standard format and specifications as revised in March 1998. The version of the Manual Abstract Reporting Form (OSHPD 1370) to be used is as revised in March 1998. Copies of Form 1370

shall be made by the hospital to submit its discharge data and each additional copy shall be made on one sheet, front (Page 1 of 2) and back (Page 2 of 2).

Authority: Section 128755, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

#### **97245. Online Test Option.**

Reports may be tested before formal submission to the Office using the online test option. Online testing of reports through the MIRCal online test option before formal transmission is the recommended means of ensuring compliant data that meets the standards established by the Office before the due date. Reports tested through the online test option will be subject to the same processing and will generate the same reports as data that is formally submitted. Reports may be tested through the test option as many times as needed to assure that the reports meet the standards established by the Office in Section 97247.

Authority: Section 128755, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

#### **97246. Data Transmittal Requirements.**

(a) Reporting facilities submitting their own data online must use the MIRCal Online Data Transmittal by Facility method to file or submit their discharge data reports. The following information must be included: the facility name, the unique identification number specified in Section 97210, the beginning and ending dates of the report period, the number of records in the report and the following statement of certification:

I certify under penalty of perjury that I am an official of this facility and am duly authorized to submit these data; and that, to the extent of my knowledge and information, the accompanying records are true and correct, and that the definitions of the data elements in Subsection (g) of Section 128735 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this facility.

(b) Reporting facilities that choose to designate an agent to submit their records must submit a hardcopy Agent Designation Form (OSHDPD 1370.3, Revised: 05/16/2002), hereby incorporated by reference, to the Office's Discharge Data Program. Receipt of a subsequent hardcopy Agent Designation Form supercedes the previous designation. Each hospital shall notify the Office's Discharge Data Program within 15 days after any change in designated agent.

(c) An agent who has been designated by a reporting facility to submit that facility's data online must use the MIRCal Online Data Transmittal by Agent method to file or submit discharge data reports. The following information must be included: the

facility name, the facility identification number specified in Section 97210, the beginning and ending dates of the report period, and the number of records in the report.

(d) Reporting facilities with an approved exemption to submit their discharge abstract data records using Manual Abstract Reporting Forms (OSHDPD 1370, Revised: 3/99), computer tape (reel or cartridge), diskette, or compact disk, must submit a hardcopy Individual Hospital Transmittal Form (OSHDPD 1370.1, Revised: 12/10/98), hereby incorporated by reference. The Individual Hospital Transmittal Form should accompany the discharge data report.

(e) Agents who have been designated by a reporting facility to submit a facility's discharge data report in accordance with an approved exemption as described in (d) above must submit a hardcopy Agent's Transmittal Form (OSHDPD 1370.2, Revised: 12/10/98), hereby incorporated by reference. The Agent's Transmittal Form should accompany the facility's discharge data report.

(f) A facility's administrator may designate no more than 3 Facility User Account Administrators. For each Facility User Account Administrator there must be an original signed Facility User Account Administrator Agreement Form (OSHDPD 2002.1, Revised: 02/01/2002, and hereby incorporated by reference), submitted to the Office.

(g) A signed Designated Agent User Agreement Form (OSHDPD 2002.2, Revised: 02/01/2002), hereby incorporated by reference, must be submitted to the Office by an agent who has been designated to submit data online.

(h) Health Facilities and designated agents may obtain copies of the forms from the OSHDPD web site at [www.oshpd.state.ca.us](http://www.oshpd.state.ca.us) or by contacting the Office's Discharge Data Program at (916) 324-6147.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

#### **97247. Approval Criteria.**

(a) The following requirements must be met for a report to be approved by the Office:

(1) Complete transmittal information must be submitted with each report.

(2) The facility identification number stated in the transmittal information must be consistent with the facility identification number on each of the records in the report.

(3) The report period stated in the transmittal information must be consistent with all of the records in the report.

(4) The number of records stated in the transmittal information must be consistent with the number of records contained in the report.

(5) All inpatient discharges, as defined by Subsection (d) of Section 97212, must be reported.

(6) The data must be reported in compliance with the format specifications in Section 97215.

(7) The data must be at, or below, the Error Tolerance Level specified in Section 97248.

(8) The data must be consistent with the hospital's anticipated trends and comparisons, except as in (A) below:

(A) If data are correctly reported and yet are inconsistent with the hospital's anticipated trends and comparisons, the hospital may submit to the Office a written explanation detailing why the data are correct as reported. The Office may determine, upon review, that it will approve a report.

(b) The Office shall approve or reject each report within 15 days of receiving it. The report shall be considered not filed as of the date that the facility is notified that the report is rejected. Notification of approval or rejection of any report submitted online shall not take more than 15 days unless there is a documented MIRCAl system failure.

Authority: Sections 128810, and 128755, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

**97248. Error Tolerance Level.**

(a) The Error Tolerance Level for discharge data reported to the Office shall be no more than 2%. Errors as defined in Subsection (g) of Section 97212, must be corrected to the ETL.

(b) For discharge data reports that do not exceed the Error Tolerance Level specified in (a), defaults will be as shown in Table 1.

<b>Table 1: Discharge Data Defaults</b>	
<b>Invalid Data Element</b>	<b>Default</b>
Admission date	delete record

Discharge date	delete record
Principal Diagnosis	799.9
Condition Present at Admission for Principal Diagnosis	Yes
All other data elements	blank or zero

Authority: Section 128755, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

#### **97249. Hours of Operation.**

The MIRCAl System will be supported from 8:00 a.m. to 5:00 p.m., Monday through Friday (except for Official State Holidays). System maintenance may cause intermittent MIRCAl system unavailability. Contact the Discharge Data Program at (916) 324-6147 to report possible MIRCAl transmission problems.

Authority: Section 128755, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

#### **97250. Failure to File a Discharge Data Report.**

Any health facility which does not file any report completed as required by this article is liable for a civil penalty of one hundred dollars (\$100) a day to be assessed and recovered in a civil action brought in the name of the people of the State of California by the Office for each day that the filing of the report is delayed, considering all approved extensions of the due date as provided in Section 97241. Assessed penalties may be appealed pursuant to Section 97052. Within fifteen days after the date the reports are due, the Office shall notify the health facility of reports not yet received, the amount of the liability, and potential future liability for failure to file reports when due.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.